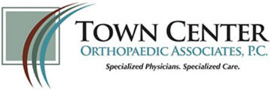

TOWN CENTER ORTHOPAEDIC ASSOCIATES

1860 Town Center Drive, Suite 300, Reston VA, 20190
Phone: 703-483-4681 Fax 703-662-4506

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________________ ______________________________
(Print patients full name) **Birth date (Mo/Day/Yr)**

______________________________________ ______________________________
(Street address) **Social security number (optional)**

______________________________________ ______________________________
(City, state, zip code) **Phone (Home)**

______________________________________ ______________________________
(Parent/Guardian if Patient<18 yrs)

At the request of the individual, I ________________________________, do hereby authorize ***TCOA*** to release
Patient Name

SERVICE DATES OF____

______OPERATIVE NOTES _______RADIOLOGY REPORTS ________ENTIRE CHART _________ PHY THERAPY
______OFFICE NOTES _______LAB/PATH REPORTS ________SPECIFIC INJURY_______________________________

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASED TO: ____
Name of Company/Agency/Facility/Person

____
Address

_______ E-delivery available to patient's personal email, ***must complete additional form available from TCOA*** **PURPOSE OF DISCLOSURE:**

______REFERRAL TO SPECIALIST ______INSURANCE ______WORKERS COMP ______LEAVING PRACTICE
______LEGAL INVESTIGATION ______DISABILITY DETERMINATION ______PERSONAL ______RELOCATION/MOVING

OTHER (SPECIFY)____

Please provide preferred telephone number in the event we need to contact you: _________________________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

NOTE: <u>CIOX HEALTH WILL PROVIDE ONE COPY OF RECORDS FOR PERSONAL USE, OR CONTINUING CARE AT NO CHARGE. RECORDS WILL BE SENT BY STANDARD MAIL. CIOX DOES NOT FAX. IF APPLICABLE, VA STATE RATES APPLY. PGS 1-50, $0.50 EACH, PGS 51+ $0.25 EACH, PLUS POSTAGE.</u>

______________________________________ ___________________________
Signature of individual or guardian or **Date**
Personal Representative of patient's estate
Power of Attorney Must Be Attached

MEDICAL INFORMATION RELEASED BY CIOX HEALTH

ENTIRE_______ LAB_________ EKG____________ ____________________________________
DS___________ EKG_________ IMMUNE________ ROI SPECIALIST
OP___________ X-Ray________ OTHER_______________________ ____________________________________
HP___________ PATH________ _______________________________ DATE

Revised 05.2020